MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-010602
STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1418

FILED MAR 18 1963

DO NOT WRITE ON THIS STUB — AMENDED

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS — ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY: Butler
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Poplar Bluff
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Doctors Hospital Inc.
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Wayne
c. CITY OR TOWN: Williamsville
Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): Rt. 2
Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Sherry Middle: Lynn Last: Drake

4. DATE OF DEATH: Month: Feb. Day: 26 Year: 1963

5. SEX: Female
6. COLOR OR RACE: White
7. Married [ ] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 2/25/63
9. AGE (last birthday)
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: 24 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country)
12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME: Edwin Gale Drake
13b. MOTHER'S MAIDEN NAME: Sherry Susan Horspool
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi
16. SOCIAL SECURITY NO.
17. INFORMANT: Edwin Gale Drake Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ATELECTASIS OF LUNGS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): PREMATURE INFANT.

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-25-63 to 2-26-63 and last saw her/him alive on 2-26-63
Death occurred at 11:45 Pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Fred Caldwell M.D.
22b. ADDRESS: Poplar Bluff, Mo.
22c. DATE SIGNED: 1/MAR/63

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 2/27/63
23c. NAME OF CEMETERY OR CREMATORY: Little Brushy.
23d. LOCATION (City, town, or county) (State): Pupico Mo.

24. FUNERAL DIRECTOR ADDRESS: Reverend Shelton Pupico Mo.
25. DATE RECD. BY LOCAL REG.: 3/14/1963
26. REGISTRAR'S SIGNATURE: Thelma Graham

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.